Michigan HIV Medical Case Management
PILOT Biopsychosocial Assessment

Client Information

Full Legal Name			**Date of birth**	
Preferred Name			**Gender Pronoun**	
Street Address				**City**
State	**Zip**	**County**	**Send mail to this address?** ☐Yes ☐No	**Confidential mail required?** ☐Yes ☐No
Mailing Address (if different from above)				**City**
State	**Zip**	**County**	**Send mail to this address?** ☐Yes ☐No	**Confidential mail required?** ☐Yes ☐No

Home Phone	**Leave a message?** ☐Yes ☐No	**Send text?** ☐Yes ☐ No	**Confidential message?** ☐Yes ☐No
Cell Phone	**Leave a message?** ☐Yes ☐No	**Send text?** ☐Yes ☐ No	**Confidential message?** ☐Yes ☐No
Alt Phone	**Leave a message?** ☐Yes ☐No	**Send text?** ☐Yes ☐ No	**Confidential message?** ☐Yes ☐No
Email address	**Send email to this address?** ☐Yes ☐No		**Confidential message?** ☐Yes ☐No

Marital Status
☐Single ☐Partnered ☐Married ☐Separated ☐Divorced ☐Widowed

Emergency Contact Information

Name	**Relationship**		
Phone	**Leave a message?** ☐Yes ☐No	**Send text?** ☐Yes ☐No	**Confidential message?** ☐Yes ☐No
Is this person aware of your HIV status? ☐Yes ☐No	**Is this person on your ROI?** ☐Yes ☐No	**Other Information**	
Name	**Relationship**		
Phone	**Leave a message?** ☐Yes ☐No	**Send text?** ☐Yes ☐No	**Confidential message?** ☐Yes ☐No
Is this person aware of your HIV status? ☐Yes ☐No	**Is this person on your ROI?** ☐Yes ☐No	**Other Information**	

Transportation

Do you have access to transportation for healthcare appointments? ☐Yes ☐No	**Do you need financial assistance with transportation?** ☐Yes ☐No

What type of transportation do you use?
☐Personal vehicle ☐Volunteer/friends ☐Public transportation ☐Taxi service ☐Van service
☐Other:

Transportation

Do you have disabilities that impact your access to transportation? ☐Yes ☐No	If yes, what disability?
Comments:	

Housing

Type of housing:
☐Rental ☐Own home ☐Nursing home ☐Hospital ☐Transitional living facility ☐Shelter
☐Living with others ☐Living on streets ☐Living in my car ☐Prison/jail
☐Other:

Is your housing stable? ☐Yes ☐No	If homeless, do you need help finding shelter? ☐Yes ☐No	Number of people in household:

Who do you live with?

Name	Relationship	DOB (minors)	Aware of your HIV status?
			☐Yes ☐No
			☐Yes ☐No
			☐Yes ☐No

Is housing subsidized? ☐Yes ☐No	By whom?	How much?
Have you applied for subsidized housing? ☐Yes ☐No	Where?	
Do you have past due rent/mortgage/utilities? ☐Yes ☐No / Are you under threat of eviction/shut-off? ☐Yes ☐No	If yes to either question, explain:	
Are you satisfied with current housing? ☐Yes ☐No	If no, explain:	
Do you have adequate furniture and appliances in your home? ☐Yes ☐No	If no, explain:	
How do you describe your neighborhood? (Assess safety, walkability, distance to bus stop, etc.)		
Comments:		

Children/Dependents

Do you have children? ☐Yes ☐No	# of children	Ages	# living with you
If children don't live with you, where do they live?	Do any of the children have special needs?	If yes, what?	

Children/Dependents

	☐Yes ☐No	

Have your parental rights been terminated? ☐Yes ☐No	**Do you need assistance with caring for children?** ☐Yes ☐No
Do you need assistance with locating parenting classes? ☐Yes ☐No	**Do you need assistance disclosing status to children?** ☐Yes ☐No
Have your children been tested for HIV? ☐Yes ☐No	**If yes, how many of your children are HIV-positive?**
Clinic where they receive HIV medical care	**Name of HIV medical provider**

Do you need assistance with your children's HIV medical care/medications? ☐Yes ☐No

What is your relationship with children?

Do you have other dependents? ☐Yes ☐No	**# of dependents**	**Ages**	**# living with you**

If dependents do not live with you, where do they live?	**Do you need assistance in caring for adult dependents?** ☐Yes ☐No

What is your relationship with dependents?

Comments:

Finances and Benefits

INCOME AND EXPENSES

Do you have income? ☐Yes ☐No **If yes, complete chart below:**

MONTHLY INCOME	AMOUNT	MONTHLY EXPENSES	AMOUNT
Employment/wages (gross amount)		Rent/mortgage	
Unemployment		Utilities	
Alimony/child support		Phone	
Pension or retirement income		Food	
Social Security Retirement		Insurance premiums	
Worker's compensation		Medical expenses	
Social Security Disability Income		Medication expenses	
Supplemental Security Income		Car payment	
FIP/TANF		Transportation	
State Disability Assistance		Cable	
Veteran's Benefits		**Other:**	
Other:		**Other:**	
Other:		**Other:**	
Other:		**Other:**	
TOTAL:		TOTAL:	

Finances and Benefits	
MONTHLY INCOME – EXPENSES	
Comments:	

EMPLOYMENT/DISABILITY	
Employment Status: ☐ Full time ☐ Part time ☐ Unemployed ☐ Job training ☐ Other:	**Reason for being un/under employed:** ☐ Disabled-not HIV-related ☐ Disabled-HIV-related ☐ Disinterested ☐ Limited job skills ☐ Waiting for disability ☐ Other:
If un/under-employed, would you like assistance getting a job or going back to school? ☐Yes ☐No	**If yes, explain:**
If disabled, have you applied for disability assistance? ☐Yes ☐No	**If on disability, do you have a representative payee?** ☐Yes ☐No
Are you able to meet basic monthly needs? ☐Yes ☐No	**What financial support do you receive from family/friends?**
Do you have outstanding debt? ☐Yes ☐No	**If yes, explain:**
Highest schooling completed: ☐ 6th grade or less ☐ Between 7th and 12th grade ☐ High school diploma ☐ GED ☐ Vocational training ☐ College degree ☐ Post-graduate work ☐ Post-graduate degree ☐ Other:	
Comments:	

INSURANCE						
Do you have insurance? ☐Yes ☐No **If yes, complete chart below:**						
If no insurance, have you applied? ☐Yes ☐No		**If yes, which insurance?**				
Are you a veteran? ☐Yes ☐No	**Are you eligible for VA benefits?** ☐Yes ☐No	**Have you applied for VA benefits?** ☐Yes ☐No				
Are you eligible for Indian Health Services (IHS)? ☐Yes ☐No		**Have you applied for IHS benefits?** ☐Yes ☐No				
INSURANCE/BENEFIT TYPE		**INSURANCE/BENEFIT INFORMAITON (list HMO, plan#, contact information, benefits limits, other costs)**				
☐ Medicare ☐ Part A (Hospitalization) ☐ Part B (Medical) ☐ Part C (Advantage) ☐ Part D (Prescription)						
		Premium:	**Part B**		**Part C**	**Part D**
☐ Medicaid ☐ "Straight"/Full ☐ HMO ☐ Healthy Michigan ☐ Spenddown						
		If applicable, recertification date				
		If applicable, monthly contribution				
		If applicable, spenddown amount				

INSURANCE				
☐ Private Health Plan ☐ Employer-sponsored ☐ COBRA ☐ Individual Plan ☐ Covered under someone else's policy				
	Premium		**Med. visit co-pay**	
	Deductible		**Med. co-pay**	
	Co-insurance		**Other**	
☐ ACA Qualified Health Plan				
	Premium		**Med. visit co-pay**	
	Deductible		**Med. co-pay**	
	Co-insurance		**Other**	
☐ Medicare Supplemental Plan/ Medigap				
	Premium		**Med. visit co-pay**	
	Deductible		**Med. co-pay**	
	Co-insurance		**Other**	
☐ Veterans Insurance				
☐ Dental Insurance				

BENEFIT TYPE	BENEFIT INFORMAITON
☐ AIDS Drug Assistance Program	
☐ Insurance Assistance Program	
☐ Michigan Dental Program	
Do you carry insurance cards with you and provide them to your medical provider? ☐Yes ☐No	
Do you need any assistance with your health insurance? ☐Yes ☐No	**If yes, explain:**
Comments:	

DHS OFFICE (ADDRESS/PHONE)	DHS WORKER	OUTSTANDING DHS NEEDS

Legal

Have you ever been convicted of a crime? ☐Yes ☐No	**If yes, explain:**
Have you ever been to jail/prison? ☐Yes ☐No	**If yes, explain:**
How have you met your health needs in jail/prison?	
Do you currently have any of the following legal issues? ☐Outstanding warrants ☐Civil charges ☐Criminal charges ☐Probation ☐Parole ☐Child protective custody ☐Family court	**If yes, explain:**
Parole/Probation Officer	**Are you required to register?** ☐Yes ☐No

Do you need legal assistance with the following:		**Comments:**
☐Immigration	☐Yes ☐No	
☐Power of attorney	☐Yes ☐No ☐In place	
☐Medical power of attorney	☐Yes ☐No ☐In place	
☐Guardianship	☐Yes ☐No ☐In place	
☐Will	☐Yes ☐No ☐In place	
☐Living will	☐Yes ☐No ☐In place	
☐Permanency Planning	☐Yes ☐No ☐In place	
☐Burial arrangements	☐Yes ☐No ☐In place	
☐**Other**:	☐Yes ☐No ☐In place	

Comments:

Cultural/Linguistics

What is your preferred language?	☐Speak ☐Read ☐Write
	☐Speak ☐Read ☐Write

Do you need a translator or interpreter? ☐Yes ☐No	**Are you hearing impaired?** ☐Yes ☐No	**Do you need a sign interpreter?** ☐Yes ☐No	**Are you able to complete forms independently?** ☐Yes ☐No

Do you prefer a medical provider of a particular: Gender? ☐Yes ☐No Age? ☐Yes ☐No Other requirements? ☐Yes ☐No	**If yes, explain:**
Do you have any beliefs prohibiting: ☐Taking any medication? ☐Blood Transfusion? ☐Participating in medical research? ☐Any specific medical procedure? ☐Other:	**If any checked, explain:**
Is there anything else regarding your culture/beliefs your health care providers should be aware of? ☐Yes ☐No	**If yes, describe:**
Comments:	

HIV Knowledge and Health Literacy

(*For MCM to ask client and record response*) What is HIV?

(*For MCM to ask client and record response*) What is AIDS?

You can get HIV from the following:

Sharing needles and/or works	☐ True ☐ False	Oral sex	☐ True ☐ False
Tattoos	☐ True ☐ False	Mosquitoes	☐ True ☐ False
Piercing body parts	☐ True ☐ False	Kissing	☐ True ☐ False
Vaginal sex	☐ True ☐ False	Breastfeeding	☐ True ☐ False
Anal sex	☐ True ☐ False	Shaking hands	☐ True ☐ False

What is a CD4 count and a viral load measure?

Why is it important to monitor CD4 count and viral load?

(*For MCM to answer*) Based on the above information, rate the client's level of HIV knowledge:
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

How often do you need help reading the following:

Written information about how to take care of yourself?	☐ Always ☐ Often ☐ Sometimes ☐ Never
Written information about how to take your medications?	☐ Always ☐ Often ☐ Sometimes ☐ Never

HIV Knowledge and Health Literacy	
Witten information about medication side effects?	☐ Always ☐ Often ☐ Sometimes ☐ Never
Appointment notifications and reminders?	☐ Always ☐ Often ☐ Sometimes ☐ Never
Treatment information from your dietician, MCM, or mental health/substance abuse counselor?	☐ Always ☐ Often ☐ Sometimes ☐ Never

How often do you need help with the following:	
Figuring out the time to take medications?	☐ Always ☐ Often ☐ Sometimes ☐ Never
Figuring out if you need to eat with medications?	☐ Always ☐ Often ☐ Sometimes ☐ Never
Understanding your medical provider when he/she talks about your health?	☐ Always ☐ Often ☐ Sometimes ☐ Never
Being able to effectively communicate your needs to your medical provider?	☐ Always ☐ Often ☐ Sometimes ☐ Never
Being able to effectively negotiate your health care?	☐ Always ☐ Often ☐ Sometimes ☐ Never
Discussing your insurance with your clinic's billing office?	☐ Always ☐ Often ☐ Sometimes ☐ Never
Discussing your benefits with your insurance plan?	
Filling out your medical forms by yourself?	
Comments:	

Health and Medical Care

MEDICAL APPOINTMENTS

Are you in medical care? ☐Yes ☐No **If yes, complete chart below:**

TYPE OF PROVIDER	NAME	CLINIC NAME ADDRESS/PHONE	LAST APPOINTMENT	NEXT APPOINTMENT
Primary Care			☐ Kept ☐ Missed ☐ Rescheduled	
Infectious Disease			☐ Kept ☐ Missed ☐ Rescheduled	
Other:			☐ Kept ☐ Missed ☐ Rescheduled	
Other:			☐ Kept ☐ Missed ☐ Rescheduled	

Health and Medical Care

MEDICAL APPOINTMENTS

How often are your appointments with the ID provider?

☐ More often than once a month ☐ Once every month ☐ Once every 2-3 months ☐ Once every 6 months

Other:

Do you schedule your own appointments?	**Has your ID provider told you that your access to care is in jeopardy due to missed appointments?**
☐Yes ☐No	☐Yes ☐No

What are some reasons for missed appointments?

What will make it easier for you to keep your medical appointments?

How do you keep track of medical visits, discussions about health, labs, etc.?	**Are there health issues you feel you cannot discuss with your provider?** ☐Yes ☐No

What is the level of HIV care you receive from your medical provider? (Identify barriers related to provider-client relationship, clinic practices and services, etc.)

Comments:

HEALTH STATUS

Date of HIV diagnosis	**Mode of transmission**

How would you describe your health? (Discuss if health has improved/stayed same/declined; any significant changes in lab work; any concerns with health; if medications are working.)

Viral Load	**Date**	**Next Scheduled**	**CD4 count**	**Date**	**Next scheduled**

Within the last month, have you experienced any of the following symptoms?

☐ Thrush	☐ Headache	☐ Fatigue	☐ Skin Problems	☐ Diarrhea	☐ Memory loss
☐ Weight loss	☐ Loss of appetite	☐ Nausea/vomiting	☐ Sleep Disturbance	☐ Vision Problems	☐ Spiking Fevers

☐ Other:

TB status: ☐ Positive ☐ Negative ☐ Unknown	**TB Test Date**	**Chest X-ray Date**
Currently on TB treatment? (include on meds list) ☐Yes ☐No	**Are you adherent?** ☐Yes ☐No	**Date of completion**
Have you completed TB treatment in the past? ☐Yes ☐No		**Date of completion**

Hepatitis status: ☐ Positive ☐ Negative ☐ Unknown	**Type of Hepatitis:** ☐A ☐B ☐C	**Currently on Hepatitis treatment? (include on meds list)** ☐Yes ☐No

Vaccines	**Date(s) of completion**
☐MMR (Measles, Mumps, Rubella)	
☐Tdap (Tetanus, Diphtheria, Pertussis; once every 10 years)	
☐Hepatitis A	
☐Hepatitis B	

HEALTH STATUS	
☐Flu (once a year)	
☐Pneumovax (Pneumonia; repeat every 5 years)	
☐Other:	

Have you ever been diagnosed with or treated for an opportunistic infection? ☐Yes ☐No **If yes, complete chart below:**

OPPORTUNISTIC INFECTION	DIAGNOSED	DATE OF DIAGNOSIS	TREATMENT RECEIVED	TREATMENT COMPLETED
Candidiasis (Thrush) of bronchi, trachea, esophagus, or lungs	☐Yes ☐No		☐Yes ☐No	☐Yes ☐No
Cytomegalovirus disease	☐Yes ☐No		☐Yes ☐No	☐Yes ☐No
Cytomegalovirus retinitis	☐Yes ☐No		☐Yes ☐No	☐Yes ☐No
Encephalopathy	☐Yes ☐No		☐Yes ☐No	☐Yes ☐No
Herpes simplex virus	☐Yes ☐No		☐Yes ☐No	☐Yes ☐No
Histoplasmosis	☐Yes ☐No		☐Yes ☐No	☐Yes ☐No
Invasive cervical cancer	☐Yes ☐No		☐Yes ☐No	☐Yes ☐No
Kaposi Sarcoma	☐Yes ☐No		☐Yes ☐No	☐Yes ☐No
Lymphoma	☐Yes ☐No		☐Yes ☐No	☐Yes ☐No
Mycobacterium Avium Complex	☐Yes ☐No		☐Yes ☐No	☐Yes ☐No
Pneumocystis carinii pneumonia (PCP)	☐Yes ☐No		☐Yes ☐No	☐Yes ☐No
Pneumonia, recurrent	☐Yes ☐No		☐Yes ☐No	☐Yes ☐No
Toxoplasmosis	☐Yes ☐No		☐Yes ☐No	☐Yes ☐No
Wasting syndrome	☐Yes ☐No		☐Yes ☐No	☐Yes ☐No
Other:	☐Yes ☐No		☐Yes ☐No	☐Yes ☐No

Have you ever been hospitalized for any illness (including an OI)? ☐Yes☐No **If yes, complete chart below:**

DATE	HOSPITAL	REASON FOR HOSPITALIZATION

Besides HIV, do you have any other conditions, illness, or diseases? ☐Yes ☐No **If yes, complete chart below:**

HEALTH CONDITION	DATE OF DIAGNOSIS	TREATMENT RECEIVED	TREATMENT COMPLETED

HEALTH STATUS			
		☐Yes ☐No	☐Yes ☐No
		☐Yes ☐No	☐Yes ☐No
		☐Yes ☐No	☐Yes ☐No
		☐Yes ☐No	☐Yes ☐No
Comments:			

SEXUAL AND REPRODUCTIVE HEALTH		
What sex were you assigned at birth? ☐Male ☐Female ☐Other:		
Have you experienced any sexual or reproductive surgeries? ☐Yes ☐No	**If yes explain:**	
What are your thoughts on family planning?		**Is family planning in place?** ☐Yes ☐No
Describe what you know about HIV and pregnancy:		
How frequently do you get tested for STIs? ☐Yes ☐No	**When was your last STI test?**	**Do you believe you currently have an STI?** ☐Yes ☐No

Have you ever been diagnosed with a sexually transmitted infection? ☐Yes ☐No **If yes, complete chart below:**

SEXUALLY TRANSMITTED INFECTION	DATE OF DIAGNOSIS	TREATMENT RECEIVED	TREATMENT COMPLETED
		☐Yes ☐No	☐Yes ☐No
		☐Yes ☐No	☐Yes ☐No
		☐Yes ☐No	☐Yes ☐No
		☐Yes ☐No	☐Yes ☐No
		☐Yes ☐No	☐Yes ☐No

Comments:

WOMEN'S HEALTH			
Date of last OB/GYN exam	**Date of last Vaginal Pap**	**Date of last Anal Pap**	**Date of last mammogram**
Results of last Vaginal Pap	**Results of last Anal Pap**	**Results of last mammogram**	
Did any of the test results require follow-up? If so, did you follow-up?			

WOMEN'S HEALTH			
Are you pregnant? ☐Yes ☐No	**Estimated # of weeks**	**Receiving prenatal care?** ☐Yes ☐No	**On antiretroviral therapy?** ☐Yes ☐No
Have you ever given birth? ☐Yes ☐No	**Number of times**	**Explain any pregnancy related complications:**	
Do you believe you had HIV during your previous pregnancies? ☐Yes ☐No	**If yes, describe your experience:**		
Are you currently breastfeeding? ☐Yes ☐No			
Other women's health issues/comments:			

MEN'S HEALTH		
Date of last prostate exam	**Date of last testicular exam**	**Date of last Anal Pap**
Results of last prostate exam	**Results of last testicular exam**	**Results of last Anal Pap**
Did any of the test results require follow-up? If so, did you follow-up?		
Other men's health issues/comments:		

TRANSGENDER HEALTH	
Are you on hormone replacement therapy? ☐Yes ☐No	**Date hormone replacement therapy started**
How do you access hormone replacement therapy?	
Name of prescribing provider/clinic	
If not through prescribing provider, is PCP/HIV care provider aware? ☐Yes ☐No	
Other transgender health issues/comments:	

ORAL HEALTH				
Do you receive regular dental care? ☐Yes ☐No **If yes, complete chart below:**				
TYPE OF PROVIDER	**NAME**	**CLINIC NAME ADDRESS/PHONE**	**LAST APPOINTMENT**	**NEXT APPOINTMENT**
Dental			☐ Kept ☐ Missed ☐ Rescheduled	
Other:			☐ Kept ☐ Missed ☐ Rescheduled	
What are some reasons for missed appointments?				

ORAL HEALTH
How often are your appointments with the dental provider? ☐ More often than once a month ☐ Once every month ☐ Once every 2-3 months ☐ Once every 6 months Other:
Do you schedule your own appointments? ☐Yes ☐No
What will make it easier for you to keep your dental appointments?
What is the level of care you receive from your dental provider? (Identify barriers related to lack of access, fear, etc.)
Comments:

VISION HEALTH				
Do you receive regular vision care? ☐Yes ☐No **If yes, complete chart below:**				
TYPE OF PROVIDER	**NAME**	**CLINIC NAME ADDRESS/PHONE**	**LAST APPOINTMENT**	**NEXT APPOINTMENT**
Vision			☐ Kept ☐ Missed ☐ Rescheduled	
Other:			☐ Kept ☐ Missed ☐ Rescheduled	
What are some reasons for missed appointments?				
How often are your appointments with the vision care provider? ☐ More often than once a month ☐ Once every month ☐ Once every 2-3 months ☐ Once every 6 months Other:				
Do you schedule your own appointments? ☐Yes ☐No				
What will make it easier for you to keep your vision care appointments?				
What is the level of care you receive from your vision care provider? (Identify barriers related to lack of access, fear, etc.)				
Comments:				

Medication Adherence				
Are you taking any prescription or over the counter medications? ☐Yes ☐No If **yes, complete the MEDICATION CHART.**				
Are you taking herbal or alternative medications/therapies? ☐Yes☐No **If yes, complete chart below:**				
HERBAL	**ALTERNATIVE**	**NAME OF MEDICATION/THERAPY**	**PROVIDER**	**PURPOSE**
☐	☐			
☐	☐			

Medication Adherence

☐	☐			
☐	☐			

Is your ID provider aware of these herbal/alternative medications/therapies? ☐Yes☐No

How do you receive your medications?	**Do you have difficulty filling/refilling your medications?**
☐ Pick up at pharmacy ☐ Delivery ☐ Other:	☐Yes ☐No

If yes, what type of problems?

Name of Primary Pharmacy	**Name of Secondary Pharmacy**

Where do you store your medications?	**Do you believe your medications are stored safely?**	**Do you hide your medications from others?**
	☐Yes ☐No	☐Yes☐No

How do you take your medications?	**Rate your ability to take your medication as prescribed over the last 7 days:**
☐ Given by another person ☐ Self-administered ☐ Other:	☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Have you missed doses in:			**What do you do when you miss a dose?**
24 hours: ☐Yes ☐No	How many?		
3 days: ☐ Yes ☐No	How many?		
7 days : ☐Yes ☐No	How many?		
1 month : ☐Yes ☐No	How many?		

What are some reasons for missing doses?

☐ I get too busy	☐ I forget	☐ I feel overwhelmed
☐ I feel depressed	☐ I am tired of taking pills	☐ I run out of pills
☐ I have too many pills	☐ I can't afford medications	☐ I get side-effects
☐ I just don't want to take them	☐ I have problems swallowing	☐ I need breaks from taking pills
☐ I am away from home when it is time to take my pills	☐ There is a change in my routine	☐ I have trouble remembering to eat or not to eat with pills

☐ Other:

Are you experiencing difficulty with any of the following?

☐ Understanding instructions for medications	☐ Not taking proper # of medications
☐ Taking medications prescribed for others	☐ Not taking medications on time

☐ Other:

Do you experience side effects with HIV medications? ☐Yes ☐No **If yes, complete chart below to identify the severity.**

SIDE EFFECTS	SEVERE	SOMEWHAT	A LITTLE	NOT AT ALL	NOT SURE
Diarrhea	☐	☐	☐	☐	☐
Nausea	☐	☐	☐	☐	☐
Vomiting	☐	☐	☐	☐	☐
Constipation	☐	☐	☐	☐	☐
Headache	☐	☐	☐	☐	☐
Skin Rash	☐	☐	☐	☐	☐
Bad Dreams or confusion	☐	☐	☐	☐	☐
Fever	☐	☐	☐	☐	☐

Medication Adherence					
Taste alteration	☐	☐	☐	☐	☐
Discoloration of skin or nails	☐	☐	☐	☐	☐
Numbness /tingling	☐	☐	☐	☐	☐
Drowsiness	☐	☐	☐	☐	☐
Loss of sex drive	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐
What have you done about the side effects?					
What will make it easier for you to take your medications?					
Comments:					

Food and Nutrition			
Current Weight		**Current Height**	
Describe your appetite. (Include # of meals per day; type of food)			
Are you experiencing any physical problems that make it difficult to eat? ☐Yes ☐No			
☐ Mouth problems	☐ Food allergies	☐ Nausea	☐ Diarrhea
☐ Swallowing problems	☐ Vomiting	☐ Taste Alteration	☐ Other:
Do you have any dietary restrictions? ☐Yes ☐No	**If yes, what are they?**		
Have you gained or lost a significant amount of weight in the last 6 months? ☐Yes ☐No	**Describe the reasons for the significant weight gain/loss.**		
Are you being treated for a weight gain or loss problem? ☐Yes ☐No	**If yes, what is the treatment?**		
Are you receiving medical nutrition therapy? ☐Yes ☐No	**Name of Dietitian**		
Do you have access to enough food? ☐Yes ☐No	**If no, explain:**		
Are you taking nutritional or vitamin supplements? ☐Yes ☐No	**If yes, which supplements?**	**If yes, who prescribed them?**	
Comments:			

Activities of Daily Living					
Check level of functioning for each activity of daily living:					
FUNCTION	**INDEPENDENT**	**NEEDS HELP**	**DEPENDENT**	**DOES NOT DO**	**NOT SURE**
Bathing	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐

Activities of Daily Living

Grooming	☐	☐	☐	☐	☐
Oral Care	☐	☐	☐	☐	☐
Toileting	☐	☐	☐	☐	☐
Transferring	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐
Climbing Stairs	☐	☐	☐	☐	☐
Eating	☐	☐	☐	☐	☐
Shopping	☐	☐	☐	☐	☐
Cooking	☐	☐	☐	☐	☐
Managing medications	☐	☐	☐	☐	☐
Using the phone	☐	☐	☐	☐	☐
Housework	☐	☐	☐	☐	☐
FUNCTION	**INDEPENDENT**	**NEEDS HELP**	**DEPENDENT**	**DOES NOT DO**	**NOT SURE**
Doing Laundry	☐	☐	☐	☐	☐
Driving	☐	☐	☐	☐	☐
Managing finances	☐	☐	☐	☐	☐

Do you have a physical disability that impacts your daily activities? ☐Yes ☐No	**If yes, explain:**

What medical devices/durable medical equipment do you need?

Are you receiving home care? ☐Yes ☐No	**Name of nurse/home care agency:**	**Type of service:** ☐Skilled Nursing ☐Chore services ☐Physical/occupational therapy ☐Other:

If you are currently not enrolled, are you in need of an evaluation for home care services? ☐Yes ☐No

Comments:

Mental Health

How is your general mood/emotional health?

How do you cope with HIV? What has been the hardest challenge in living with HIV?

What symptoms are you been experiencing?

☐Sleep problems	☐Dread/fear	☐Feeling hopeless	☐Fatigue
☐Sad Mood	☐Hard time remembering	☐Crying	☐Anger
☐Difficulty concentrating	☐Reliving past events	☐Irritability	☐Worried thoughts
☐Feeling bad about yourself	☐Relationship/family problems	☐Feeling nervous	☐Distress/worry about HIV
☐Concerned about the future	☐Seeing or hearing things others do not	☐Worry about medical condition(s)	☐Having the same thoughts repeatedly

Mental Health

☐ Decreased interest in things you usually enjoy	☐Other:

Have you had thoughts about hurting yourself, taking your life, or harming someone else? ☐Yes ☐No	**How recently?**
Describe the circumstances (assess ideation, plan, intent, names of people client wants to harm).	
Have you ever attempted suicide? ☐Yes ☐No	**What happened?**
Do you feel unsafe in any current relationship or place of residence? ☐Yes ☐No	**If yes, explain:**

Do you have a history of mental health diagnoses? ☐Yes ☐No **If yes, complete chart below:**

MENTAL HEALTH CONDITION	DATE OF DIAGNOSIS	COMMENTS

Have you ever sought treatment for mental health issues? ☐Yes ☐No **If yes, complete chart below.**
Examples of modalities: inpatient hospitalization; outpatient individual/group therapy; family counseling; crisis interventions

PAST DATES	TREATMENT MODALITY	TREATMENT FACILITY	COMPLETED?
			☐Yes ☐No ☐Ongoing
			☐Yes ☐No ☐Ongoing
			☐Yes ☐No ☐Ongoing
			☐Yes ☐No ☐Ongoing
			☐Yes ☐No ☐Ongoing

List information for the most recent/current mental health provider(s).

TYPE OF PROVIDER	NAME	CLINIC NAME ADDRESS/PHONE	LAST APPOINTMENT	NEXT APPOINTMENT
Therapist/Counselor			☐ Kept ☐ Missed ☐ Rescheduled	
Group Counselor				

Mental Health				
			☐ Kept ☐ Missed ☐ Rescheduled	
Psychiatrist			☐ Kept ☐ Missed ☐ Rescheduled	
Other:			☐ Kept ☐ Missed ☐ Rescheduled	

How often are your appointments with mental health provider(s)?
☐ Once a month ☐ Every 2 weeks ☐ Once a week
Other:

What are some reasons or barriers that prevented you from maintaining mental health treatment?

Do you schedule your own appointments? ☐Yes ☐No

What will make it easier for you to keep your mental health appointments?

What is the level of care you receive from your mental health provider?

Comments:

Substance Use and Treatment

Do you have a history of substance use/abuse? ☐Yes ☐No **If yes, complete chart below.**

SUBSTANCE	AMOUNT/FREQUENCY (daily, weekly, monthly)	ROUTE (oral, nasal, smoke, IVDU)	DATE OF LAST USE
Nicotine/Tobacco			
Alcohol			
Marijuana			
Cocaine			
Crack			
Prescription drugs			
Heroin			
Hallucinogens			

Substance Use and Treatment			
Crystal Meth			
Inhalants			
LSD/PCP			
Other:			
Other:			
Other:			
Describe history of substance use/abuse. (Drug of choice, age started, triggers, etc.)			

Have you ever sought treatment for substance use/abuse? ☐Yes ☐No **If yes, complete chart below.**

PAST DATES	TREATMENT MODALITY	TREATMENT FACILITY	COMPLETED?
			☐Yes ☐No
			☐Yes ☐No
			☐Yes ☐No

What are some reasons or barriers that prevented you from completing treatment?

Are you currently in substance abuse treatment? ☐Yes ☐No **If yes, complete chart below.**

TREATMENT MODALITY	DATE	COMMENTS
Stop smoking program		
Methadone maintenance		
Detox		
Inpatient substance use program		
Outpatient substance use program		
AA/NA or other self-help group		

TREATMENT PROGRAM (ADDRESS/PHONE)	TREATMENT COUNSELOR	DATE WHEN TREATMENT ENDS

Does your substance use prevent you from going to medical appointments and/or taking your medications? ☐Yes ☐No

Are you in recovery? ☐Yes ☐No	**What has been your longest period of abstinence?**

What has helped you remain in recovery?

What are your relapse triggers?

If client is actively using substances, answer the following questions:

Substance Use and Treatment

If you inject substances, describe how you keep yourself safe from further injection-related harm?

Do you utilize a needle exchange? ☐Yes ☐No	**Do you have a history of overdosing?** ☐Yes ☐No	**Are harm reduction methods being used?** ☐Yes ☐No
If no, are you interested in a referral? ☐Yes ☐No	**(Alcohol use) Do you have a history of Delirium Tremens (DT)?** ☐Yes ☐No	**Would you like assistance to connect with Partner Services?** ☐Yes ☐No
Are you interested in stopping drug use? ☐Yes ☐No	**Would you like a referral to substance use treatment?** ☐Yes ☐No	**Are you interested in learning more about overdose prevention and/or harm reduction?** ☐Yes ☐No

Comments:

HIV Prevention and Risk Reduction

Are you sexually active? ☐Yes ☐No	**How many sexual partners have you had within the past 2 months?**	**How do you meet your sexual partners? (Online, bathhouses, clubs, friends, etc.)**
What are the genders of your sexual partners? ☐Male ☐Female ☐Transgender ☐Other:	**Describe how you negotiate safer sex for yourself and your partners. (Condoms, viral suppression, serosorting, etc.)**	
Are you currently virally suppressed? ☐Yes ☐No	**Do your HIV negative partners have access to PrEP prevention supplies?** ☐Yes ☐No	**If yes, describe how you negotiate PrEP with your partners:**
What HIV/STD prevention methods do you use when having sex? ☐Condom ☐Dental dam ☐Saran Wrap ☐Latex gloves ☐Withdrawal ☐Other:	**Do you have access to barrier methods (e.g. condoms)?** ☐Yes ☐No	**(*For MCM to answer*) Can client describe the proper use of condoms?**

I may not use barrier methods when:

☐When I am sexually excited	☐When I feel angry or upset	☐When I am with a new partner
☐When I am the top	☐When I am the bottom	☐When I am drinking and/or high
☐ When I feel bad about myself	☐Condoms don't feel good	☐When I am seeking drugs/money
☐When there's not much risk	☐ When I'm undetectable	☐When I'm not expecting sex
☐When my partner pressures me to not use condoms	☐When my partner(s) are HIV-positive	☐Other:

How often do you disclose your HIV status with sexual partners?	**Is there anything about safer sex or sexual risk that you want to know more about?** ☐Yes ☐No	**If yes, describe:**
(*For MCM to answer*) Is the client aware of the Michigan HIV Disclosure law? ☐Yes ☐No	**If no, did the MCM make client aware of the law?** ☐Yes ☐No	
Would you like assistance to connect with Partner Services? ☐Yes ☐No	**Has your partner(s) been tested for HIV?** ☐Yes ☐No	**Do you need assistance to access HIV testing?** ☐Yes ☐No

Comments:

HIV Prevention and Risk Reduction

Social Support and Spirituality

What do you do to socialize?

What are your interests?

What type of support system do you have?	**Do you believe you have an adequate support system?**
☐None ☐Family ☐Friends ☐Religious group ☐Support group ☐Neighbors ☐Social Media ☐Other:	☐Yes ☐No

Have you told anyone about your HIV status? ☐Yes ☐No **If yes, complete chart below:**

NAME OF SUPPORT PERSON	RELATIONSHIP	SUPPORTIVE OF YOU TAKING MEDICATIONS AND GOING TO MEDICAL APPOINTMENTS?
		☐Yes ☐No
		☐Yes ☐No
		☐Yes ☐No
		☐Yes ☐No
		☐Yes ☐No

Who helps you when you are seriously ill?

Do you need help to disclose your HIV status? ☐Yes ☐No	**If yes, who?**
Is religion/faith/spirituality important to you? ☐Yes ☐No	**If yes, explain:**

List 3 strengths or positive areas in your life.

How do these strengths help you deal with your diagnosis?

(*For MCM to answer*) List 3 strengths you have identified.

Comments:

Summary of Client Needs (Per CM)

Summary of Client Needs (Per CM)

Summary of Client Needs (Per Client)

CM Signature	CM Name	Date

Medication CHART

Include all medications on this chart.

NAME OF MEDICATION	PURPOSE OF MEDICATION	PRESCRIBER (if applicable)
